Psychiatric Disorders in Addiction

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UofL Hospital

Disclosures:

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Dr. Stewart has no relevant financial disclosures

Dr. Stewart does mention the use of off label uses of medications: Alpha- 2 Selective Agonists for the treatment of PTSD.

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Objectives

- Increased understanding and competence in approaching patients with co-occurring disorder's where **one** of the problems is addiction.
- Appreciate the role that systems have historically played in addressing the problem of co-occurring disorder and the ongoing controversy of this problem
- Discussion of evidence for the role trauma in addiction and how this can impact complex presentation
- Due to time constraints the following diagnosis are not discussed in detail: Borderline Personality Disorder, Social Anxiety Disorder, Obsessive Compulsive Disorder, Schizophrenia, Panic Disorder, Generalized Anxiety, and others

Patients with Addiction and Co-occurring Disorders..

Poorer prognosis and poorer outcomes

Higher risk of suicide

Less likely to engage in outpatient therapy

More likely to present/utilize in acute medical/psychiatric settings

50-75 percent of patients in substance abuse settings

20-50 percent of patients in mental health settings

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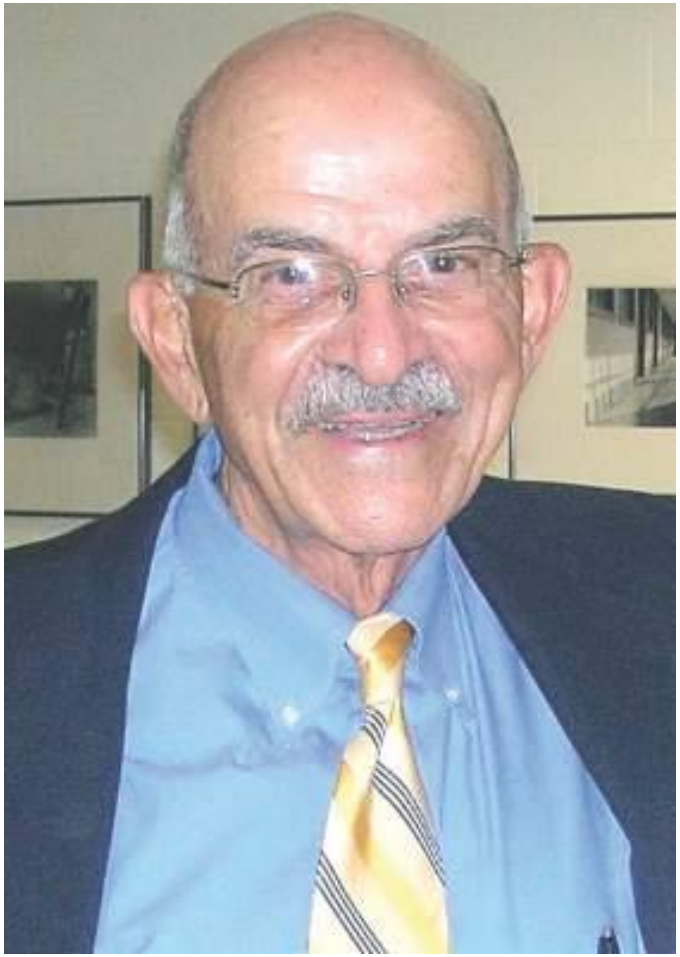
Burns Brady

- Grand Rounds, University of Louisville Department of Psychiatry 1997
- “He discussed how an addict was incorrectly diagnosed with Narcissistic Antisocial Sociopathic borderline with psychotic tendencies”
- “***Demonstrated*** that impaired physician addicts could be successfully treated with a high success rate utilizing 12 step recovery and the biopsychosocial model when applied with sincerity and compassion.”

?Self Medication Hypothesis?

- Khantzian (1982) observed that Heroin addicts were using the drug to ‘soothe’ their aggression and rage.
- Addicts were not simply seeking pleasure
- Eventually he expanded his theory to how it applied to most drugs of abuse that reduce anxiety
- Drug addicts were predisposed to use certain drugs to help with affect regulation (ADHD/Cocaine, Social Anxiety/Alcohol)
- Champion for Humanistic Approach in Addiction Treatment



DSM-V Handbook of Differential Diagnosis

"The process of DSM-5 differential diagnosis can be broken down into six basic steps:

1) ruling out Malingering and Factitious Disorder

2) ruling out a substance etiology

3) ruling out an etiological medical condition

4) determining the specific primary disorder(s)

5) differentiating Adjustment Disorder from the residual Other Specified and Unspecified conditions

6) establishing the boundary with no mental disorder. " ***DSM-V handbook of differential diagnosis.***

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My approach to differential diagnosis

Attend	Address	Approach	Approach
Attend to medical/physiological status – which includes medications, drugs they are using, medical problems.	Address safety issues to include acute mental status issues – depression, anxiety, suicidality, psychosis, mania	Approach the patient with the assumption they have a significant ACE score, considering co-addictions here as well.	Approach all patients from an attachment perspective

Assessment and treatment of depression in SUD

Anhedonia is normal in early abstinence (PAWS)

Major Depression is *considered* the number one co-occurring psychiatric disorder in SUD's.

Depressed mood is directly caused by addiction/drug use in many cases

Most cases will remit with abstinence over time

SSRI's do not provide benefit in addiction itself

SSRI's have the problem of side effects and discontinuation syndrome

SSRI's can induce mania in persons predisposed, and contraindicated in ASPD

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The seduction of a psychiatric diagnosis…..

- *ADHD and Bipolar disorder*

These diagnoses and others share a common theme:

Often missed and/or misdiagnosed/overdiagnosed

Not obvious, under the surface (like a bear in the woods)

Great imitators (like addiction!)

The “eureka” feeling and/or satisfies managed care paradigm – “Now we have an explanation”

Addicted patients in certain settings preferred to have a psychiatric diagnosis

Still, it is often true, but….

Bipolar Affective Disorder

- Prevalence 1% in the general population
- For Bipolar Type 1: A single manic episode is required
- Bipolar Type 2: A single episode of hypomania without ever having a manic episode
- Increased risks of substance abuse, approximately 60% with co-occurring substance abuse
- Cyclothymia
- No other medical cause
- Mania requires a sleep disturbance and must last for a period of seven days
- Comorbid trauma is likely

The Healing Place

THE HEALING PLACE

Where hope is found.

- "Is Bipolar disorder over diagnosed among substance abuse disorders?" *Bipolar Disorders 2006.* Stewart and El-Mallakh.
- *Interviewed subjects utilizing Structured Clinical Interview*
- *Findings were replicated*
- *45 citations*

Is Bipolar Disorder Overdiagnosed?
J Clin Psychiatry 2008;69(6):935-940
Mark Zimmerman, MD; Camilo J. Ruggero, PhD; Iwona Chelminski, PhD; and Diane Young, PhD

- 700 hundred psychiatric outpatients in Rhode Island were interviewed utilizing the SCID and also completed a self administered questionnaire
- Family history of first degree relatives obtained
- Diagnoses from the SCID were blind to the results of the self administered questionnaires
- This study was conducted from May 2001 to March 2005.

MIDAS Project

The Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project

The largest clinical epidemiological study utilizing semi structured interviews to assess psychiatric diagnosis in a community based outpatient setting

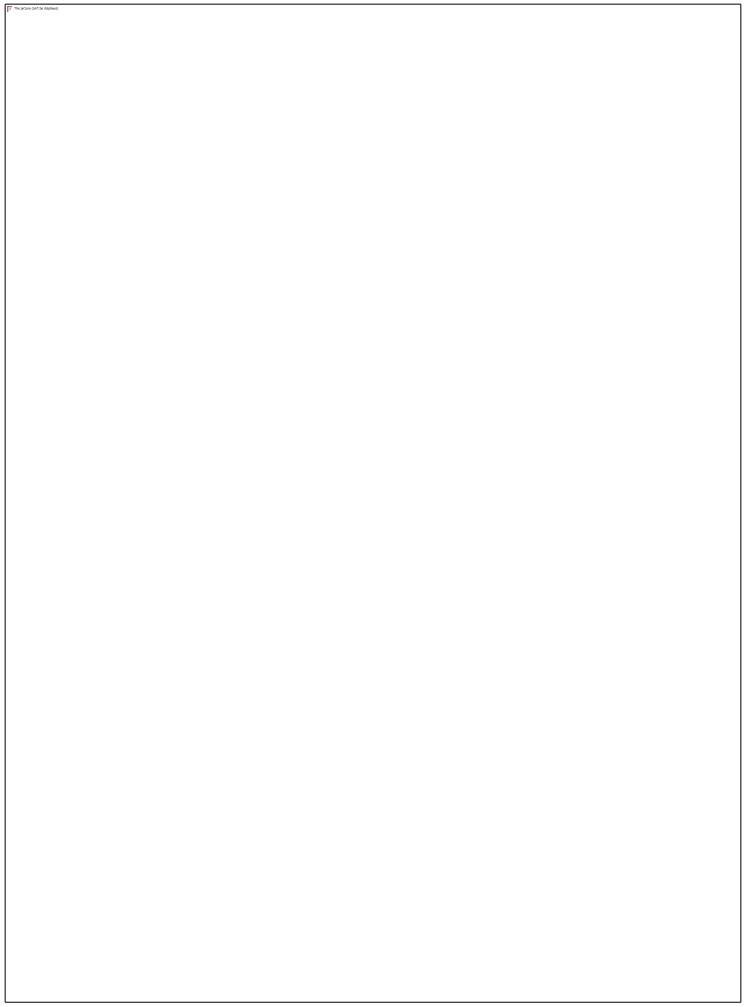
Nearly 4,000 individual interviews conducted to date

Patients seek treatment for diagnoses that are not their principal diagnosis

Bipolar disorder ***over-diagnosis*** by psychiatrists is a consistent phenomenon across the spectrum of psychiatric outpatients

ASSESSMENT OF PTSD IN SUD
from Essentials of Addiction Medicine

- Given the high rates of trauma and PTSD among individuals with SUDs, it is important to screen all SUD patients.
- As a general rule, PTSD assessment should be conducted after a patient has emerged from acute alcohol or drug intoxication and withdrawal.
- In contrast to other anxiety disorders, ***less abstinence*** may be required in order to establish a diagnosis of PTSD among SUD patients because of the unique nature of the diagnostic criteria (i.e., requirement of exposure to criterion A traumatic event).
- Intrusive PTSD symptoms (e.g., recurrent thoughts or images related to the trauma) are uniquely characteristic of PTSD and are less likely to be mimicked by substance use or withdrawal.
- Other PTSD symptoms (e.g., irritability or outburst of anger, sleep impairment) could be exacerbated by the use of, or withdrawal from, alcohol and drugs and should be carefully assessed.



Post Traumatic Stress Disorder and Addiction: **DUAL DIAGNOSIS TREATMENT PROJECT AT THE UNIVERSITY OF LOUISVILLE**

- *Integrating Cognitive Neuroscience Research and Cognitive Behavioral Treatment with Neurofeedback Therapy in Drug Addiction Comorbid with Posttraumatic Stress Disorder: A Conceptual Review* **Tato M. Sokhadze, PhD Christopher M. Stewart, MD Michael Hollifield, MD** *Journal of Neurotherapy 2007*

Dual Diagnosis Project cont'

- Sokhadze, E., Stewart, C., Sokhadze, G., Hollifield, M., & Tasman, A. (2009) Neurofeedback and motivational interviewing based bio-behavioral treatment in cocaine addiction. *Journal of. Neurotherapy, 13, 84-86*
- Sokhadze, E., Stewart, C., Sokhadze, G., Husk, M, & Tasman, A. (2009) Effects of neurofeedback-based behavioral therapy on ERP measures of executive functions in drug abuse. *Journal of Neurotherapy, 13(4), 260-262*.
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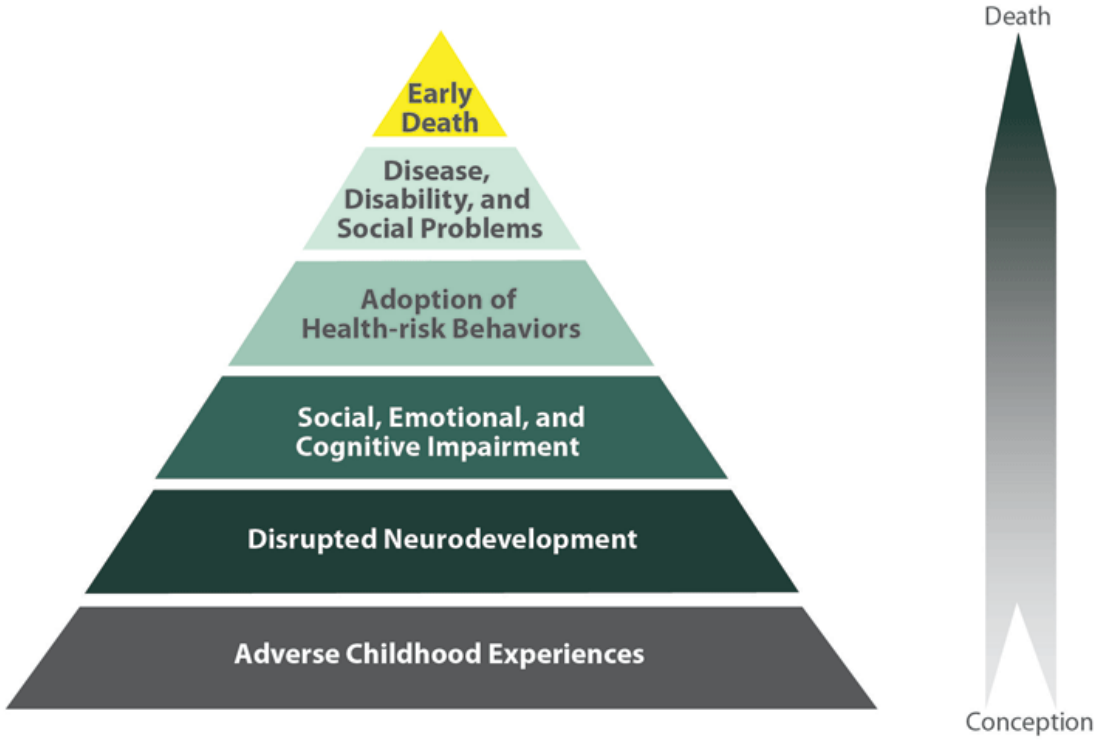
- Sokhadze, E., Stewart, C., Hollifield, M., and Tasman, A. "Event related potential study of executive dysfunctions in a speeded reaction task in cocaine addiction. *Journal of Neurotherapy*, 2008, v.12, N.4.
- Sokhadze, E., Stewart, C., Hollifield, M., and Tasman, A. "Attentional bias to drug related and stress related pictorial cues in cocaine addiction co morbid with post-traumatic stress disorder." *Journal of Neurotherapy,* 2008, v 12, N.4.

- "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults" Vincent J Felitti MD, FACP, Robert F Anda MD, MS, Dale Nordenberg MD, David F Williamson MS, PhD, Alison M Spitz MS, MPH, Valerie Edwards BA, Mary P Koss PhD, James S Marks MD, MPH

  - May 1998Volume 14, Issue 4, Pages 245–258
  - The Adverse Childhood Experiences (ACE) Study
  - The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and later-life health and well-being.
  - The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.
  - The CDC continues ongoing surveillance of ACEs by assessing the medical status of the study participants via periodic updates of morbidity and mortality data

ACE pyramid



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Adverse Childhood Events:

As the number of ACEs increases so does the risk for the following*:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease
- Liver disease
- Poor work performance
- Financial stress
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Risk for sexual violence
- Poor academic achievement

Alpha -2- Selective Agonists

- Clonidine (Kapvay, Clonidine XR)
- Guanfacine (Tenex, Intuniv)
- Prazosin (Minipres)
- Lofexidine

  – inhibits adenylyl cyclase activity, reduces brainstem vasomotor center-mediated CNS activation; used as antihypertensive, sedative & treatment of opiate dependence/withdrawal, ADHD/conduct disorder in children, post traumatic stress disorder, and alcohol withdrawal symptoms.

Alcoholics Anonymous

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ADHD and Addiction

EPIDEMIOLOGY OF ADHD AND SUBSTANCE USE DISORDERS

- The adult rate of ADHD is estimated to be from 2.5% to 4%.
- Substance use disorders (SUDs) are more common among adults with ADHD, with rates two to three times than found in the general population.

"ADHD Medication and Substance-Related Problems" *American Journal of Psychiatry 2017: 877-885.* Patrick Quinn, PhD (Indiana University), Zheng Chang, PhD., Kwan Hur, PhD., Robert D. Gibbons, PhD., Benjamin B. Lahey, PhD., Martin Rickert, PhD.,Arvid Sjolander, PhD.,Paul Lichenstein, PhD., Henrik Larsson PhD., Brian M. D'Onofrio, PhD.

- Review of commercial health care claims from 2,993,887 ADHD patients that included adolescents and adults who received either ADHD diagnosis and/or ADHD treatment with stimulant therapy or atomoxetine
- Does not settle controversy or questions regarding best approach in the treatment of co-occurring ADHD and addiction in adults
- "Medication periods" were associated with reduced risk of 'substance related events' which are defined by ambulance, inpatient, or emergency room visits related to substance use.

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Table for risk stratification in prescribing stimulants for patients with both ADHD/SUD

- **Low-Risk Group (e.g., 20 y abstinent from alcohol, no current illicit drug use)**
  - Brief office intervention
  - Advise of the risk of combining prescription stimulants with other substances
  - Warn about diversion
  - Ongoing monitoring
  - ADHD response
  - Use/abuse pattern
  - Use delayed absorption formulation when prescribing stimulants
- **Moderate-Risk Group (e.g., some substance use but not current abuse/dependence; misuse of stimulants in the past)**
  - Include strategies for low-risk group
  - More frequent office visits
  - Very close attention to patterns of alcohol/drug use
  - Urine toxicology testing
  - Use delayed absorption formulation when prescribing stimulants
- **High-Risk Group (e.g., active SUD)**
  - Include strategies for moderate-risk group
  - May try nonstimulants first
  - If poor response to nonstimulant, switch to long-acting stimulant
  - Require counseling, involvement with self-help group, or referral to appropriate substance abuse treatment
  - If severe SUD, may refer for intensive intervention prior to starting medication
  - May need to avoid stimulants if they have history or current abuser/dependence on prescription stimulants or high risk of diversion of medication (i.e., sold medication in the past)

Likelihood of a Suicide Attempt

Risk Factor	Increased Odds Of Attempting Suicide
• Cocaine use	62 times more likely
• Major Depression	41 times more likely
• Alcohol use	8 times more likely
• Separation or Divorce	11 times more likely

NIMH/NIDA ECA EVALUATION

Substance-Associated Suicidal Behavior (*from Essentials of Addiction Medicine)*

"Substance-induced depression can dissipate rapidly, but it is as dangerous as major depressive disorder in terms of the risk of suicide and self-injurious behavior. When completed suicides are investigated, the rate of comorbidity is high."

"Both independent depression and substance-induced depression are associated with suicidal ideation and planning, and aggression is correlated with suicide attempts."

Thanks

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- Estate Sokhadze

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